South Eastern Health and Social Care Trust

Chairman (Acting)
Jonathan Patton

Interim Chief Executive
Seamus McGoran

Private & Confidential

BY EMAIL

Your Ref: C221/20

19 October 2020

Colm Gildernew MLA
Chairperson
Committee for Health
Room 410
Parliament Buildings
Stormont
Belfast BT4 3XX

Dear Mr Gildernew

COVID-19 and Care Homes

I refer to your letter of 23 September 2020, on behalf of the Committee for Health, in relation to the impact of COVID-19 on care homes and seeking the view of the South Eastern Trust with a view to developing recommendations aimed at mitigating and managing a second surge in infections.

Please find South Eastern Trust response attached as requested.

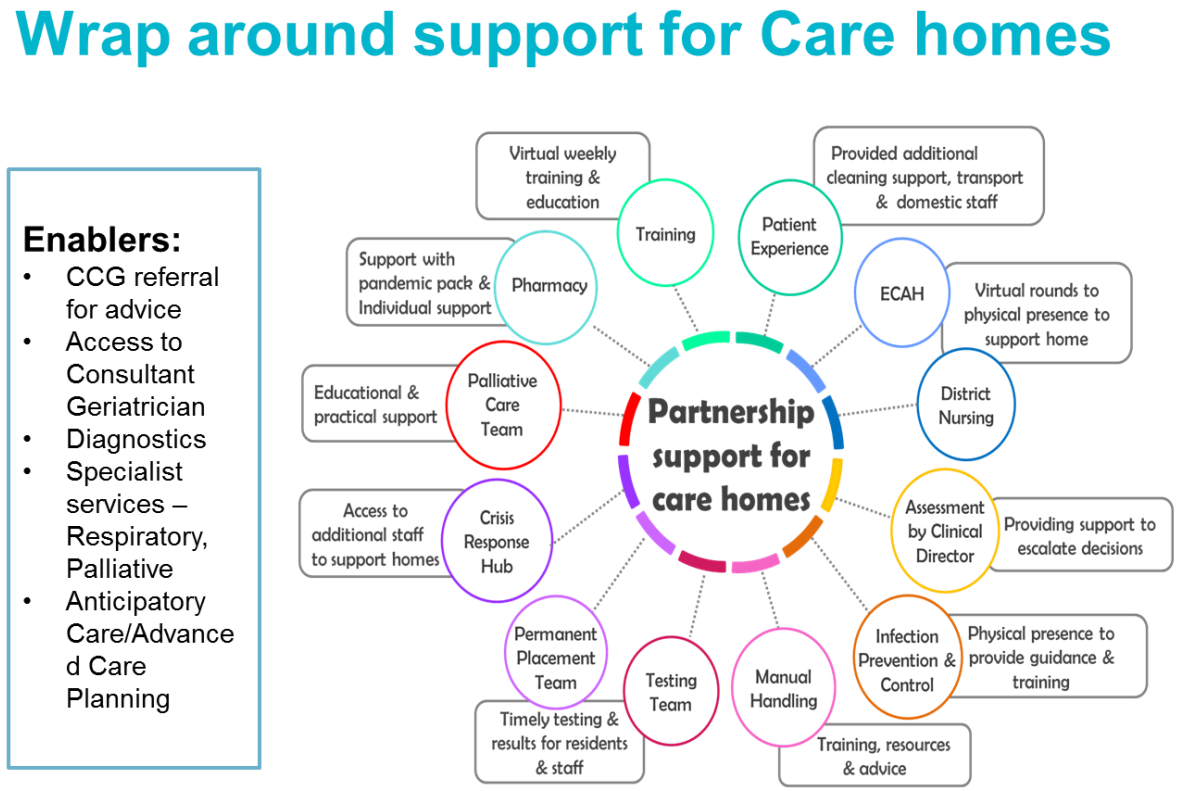
Yours sincerely

SEAMUS McGORAN
Interim Chief Executive

South Eastern Health and Social Care Trust

Response to Health Committee's request for information for inquiry into the impact of COVID 19 on Care homes

The South Eastern Trust fully recognises how challenging the Covid19 pandemic has been for our colleagues working in care homes. We have all had the common purpose of striving to protect and care for some of the most vulnerable in our society who live in these homes. The below graphic summarises the support the Trust has provided and sets the context for the response to the specific areas for which the Health Committee has requested information.



Discharge from hospitals to care homes

In line with the regional guidelines patients are swabbed within the 48 hours period prior to discharge to care homes. Significant coordination is required in achieving timely discharges, engaging laboratory staff, ward and community discharge staff, in this transition process. This process is applicable to patients returning to their place of residency, moving for a period of temporary placement or for a period of rehabilitation. The ongoing changes to the guidance as more was learnt about the virus was challenging to implement and challenging for the providers to keep abreast of requirements.

Isolation within Care Homes

Isolation proved difficult among residents who had either a cognitive impairment or a diagnosis of dementia. The Trust is now receiving numerous requests for additional funding for one to one support for these residents upon discharge from hospital to cover the 14 day isolation period. This has significant financial implications for the Trust and a heavy reliance on agency staff for the home. The regional guidance was shared with care homes in relation to infection prevention and control guidance. The requirement for isolation of residents was articulated in the guidance and care homes implemented this. The Trust communicated upon hospital discharge with the relevant home on an individual basis to ensure the home understood the requirements for that resident.

Step-down/Step Up Facilities

The Trust initially commissioned a number of block purchased beds in care homes in anticipation of the need for additional places to facilitate discharge from acute hospitals. It became clear that in terms of managing infection prevention control it was more effective to commission a service for a covid positive discharge pathway. The Trust commissioned bespoke covid positive discharge units in Northfield Residential Care home (a Trust managed residential home), Rosevale Nursing Home and Rainbow Unit (both Independent Sector facilities) with a total of 55 beds. These units facilitated discharge from acute beds, admission from the community to prevent hospital admission, or transfer of Covid+ residents from another care home to prevent spread in that care home or where care needs were such that hospital admission was not required but were above what could be managed by the home at a time of crisis. This proved effective in the containment of the virus and ensuring residents' needs were met appropriately.

Access to PPE

Care homes were invited to advise the Trust through a single point of contact what their requirements are for the provision of PPE during the COVID 19 period. Arrangements have been put in place for the delivery or collection of these products on regular intervals.

Some homes sourced the majority of their own PPE taking the spirit of the Department of Health letter on board. However, the majority of homes said they couldn't source fluid resistant masks, visors and were only able to secure limited supplies of gloves and aprons. This potentially means that some providers have spent significantly more in their efforts to provide PPE where others relied on the Trust.

Infection Prevention and Control teams from the Trust were instrumental in the practical training and support to care homes in the appropriate use of PPE and from experience this was an ongoing requirement owing to the high turnover of staff in the sector.

Security of supply

Initially there was concern regionally about the surety of supply. To support effective forecasting the Trust developed a single point of access and baseline for each home, based on the number of residents. This baseline predicted the likely requirement for a week of PPE. The Trust then developed a weekly ordering and delivery process. Any urgent requests were facilitated and the Trust supported homes in relation to training in the use of PPE.

Procurement: Central vs Individual

It makes sense that procurement for PPE is done on a central basis, making sure the independent sector have access to the required PPE. It would make sense going forward to augment existing NHS/ HSC supply chains to permit independent sector providers to access these directly. However, consideration would need to be given to how this may impact forecasting for public sector if providers were to order large volumes unchecked. Another issue would appear to be that large providers that operate both regionally and nationally didn't seem to have better access to PPE than small local providers, indeed some of the larger providers advised the Trust they struggled to obtain any PPE and relied on the Trust significantly. It could have been anticipated that these large UK wide organisations would have had access to PPE readily given their infrastructure, but this was not the case.

Testing in care homes

The Trust led on the implementation of the testing regime for both staff and residents in care home before a regional approach was implemented by the PHA. There was innovative practice such as using a mobile transport unit to test staff. This worked well in that the Trust had accurate information and fast access to results which informed decision making. This responsive service was supported by redeployed staff and the Northern Ireland Ambulance Service.

The Trust redeployed staff from various Directorates and services to support the strands of COVID 19 swabbing to assist with the implementation of testing. A full training programme of support was vital for the testing team to enable upskilling.

A centre drive through hub was set up in centrally in the Trust geography for staff that could drive and a community swabbing team was coordinated from a single point to support swabbing in care homes across the entire Trust area. The management of results, health monitoring and advice was coordinated through the central team by professional staff. The Trust encountered some resistance from residents and staff in relation to testing. To address this with staff the Trust shared legal advice in relation to health and safety guidance to support homes to engage staff. Key workers reinforced the importance of participation in testing for residents.

Trust staff currently undertake the testing of symptomatic residents and staff and outbreak testing as per the regional guidance issued on 20th August 2020.

The National Testing Initiative continues to present a number of challenges not least around turnaround times and timely communication of positive results but turnaround times are improving and the Trust is working with partners to resolve outstanding issues.

Symptom Monitoring

The Trust piloted the Public Health Agency (PHA) virtual wellness checker in conjunction with the Trust Enhanced Care at Home service and district nursing. Across all Trust residential care facilities the Trust trained staff to undertake monitoring as required on a daily basis. The Trust put in place a care home response hub as a single point of contact for all care homes and where concerns were raised in terms of symptom management or with specific clinical issues the Trust supported this through the provision of nursing or allied health profession support. The Trust implemented a clinical support team to advise and support escalated decision making within care homes. The Trust monitored on a daily basis using the regional care home monitoring matrix and proactively engaged with care homes to understand their ongoing status and requirements for support in relation to a wide range of issues which included staff, PPE, testing, clinical support, cleaning advice. Infection prevention control advice and general issues. This was all shared on a daily basis internally in the Trust.

Funding and increased costs for care homes

Since March 2020 during the COVID-19 disruption period the HSC wanted to ensure that its independent sector partners in care were supported financially to manage the cost pressures which they faced as a result of COVID-19.

Regionally a grant was paid to 370 Independent Sector Care Homes on 15 May 2020 totalling £5.4m, from the Minister's April announcement of £6.5m, the SEHSCT element was £1.5m.

Regionally a balance of £1.1m has not yet been issued and is being discussed with HSCB and DOH.

This grant was to support Care Homes to manage any COVID-19 specific cost pressures, this was issued in bands (see table below), dependent on the number of beds in the facility. Governance arrangements have been on a 'light touch' basis with a monitoring return to the HSC to advise how the Care Home applied the grant. From a review of the returns there has been a wide variety of application, e.g. staffing support, loss of income, accountancy support ref the Government's Coronavirus Job Retention Scheme, PPE and essential equipment.

Beds in Home	Grant Award
0-30	£10k
31-50	£15k
>50	£20k

1. A mainly claims based process for Care Homes within a financial envelope of £11.7m announced by the Minister in June 2020. This financial package covered 3 key areas:
    a. To assist Care Homes to pay their employees at 80% of their pre-COVID-19 average salary if they had to shield, isolate or were ill as a result of COVID-19. The period of claim confirmed by DOH was from June to August 2020.
    b. To support Care Homes to increase their level of environmental cleaning hours from June to August 2020 as set by the PHA.
    c. To support Care Homes to purchase additional essential equipment (Pulse Oximeters, Thermometers, Blood Pressure Monitors and Tablets/Communication devices), the volume of each was informed by a survey completed by the PHA in May 2020. In addition to the claims element Trusts have separately ordered Defibrillator's for Care Homes which did not currently have one, as well as purchasing an additional stock of syringe drivers to support Care Homes when required, this has cost circa £0.6m.

The current level of reimbursement is set out below for SEHSCT and the Region.

As of 09/10/2020	**SEHSCT £'000**
Value of essential equipment reimbursed (£)	112,752.45
Value of 80% sickness reimbursed (£)	21,300.59
Value of additional cleaning reimbursed (£)	214,748.34
TOTAL PAID ON CLAIMS TO DATE (£)	**348,801.38**

A number of Care Homes had not made any claim as at the end of August and all were again invited to claim with local support offered to assist. At the time of writing there are 24 Care Homes which have not claimed for any element of this support package from SEHSCT and 7 for which no evidence

of the additional costs has been provided to allow reimbursement to be made by SEHSCT. Regionally all Trusts are writing to these Care Homes again in October offering further support and encouragement.

2. 'Guidance for Nursing and Residential Care Homes in NI' issued on 17/03/20 was supported by the application of the temporary cash Payments on Account (POA), to ensure that Care Homes were supported to maintain financial resilience during COVID-19 disruption. There were 2 key elements to this:
    a. The guidance indicated in section 4f – '*Planning will also need to take account of the financial resilience of care home providers. Where, as a result of the COVID-19 outbreak a nursing or residential care home's income reduces by greater than 20% below the past 3 months' average then Trusts should block purchase 80% of the vacated beds at the regional tariff. The Trust should then fill these beds as required over the next three months. If beds are still vacant at the end of that period a further review would be undertaken by the Trust working with the Health and Social Care Board*.'
    b. In a regionally agreed letter issued by Trusts to all Care Homes on 07/04/20 it was advised that during the period of disruption an interim cash POA would be issued to Care Homes, to bring the value of payments made to the Home to a minimum of 90% of the pre-COVID-19 average payment (adjusted for 2020/21 price uplifts). This would be achieved by 'topping up' any payment for actual value of the monthly payment below 90%. If a Home's value of payment remained above 90% they did not receive any POA /cash contingency.

Putting this interim measure in place in April 2020, provided a supported, consistent cash flow for Care Homes until the collation, validation and processing of the conditions set out in '4f' (see above) could be actioned and for all monthly activity from April to be processed by Trusts, as payments for placements are generally in arrears. The expectation was that the impact of COVID-19 may have increased processing time.

Regionally Trusts have developed and agreed a methodology for the retrospective review of activity with the HSCB and DOH. All Care Homes will be provided with individual details on any adjustments required which may be an additional payment or retraction, the process commences in October relating to April's activity and will continue while the contingency arrangements are in place, or changed by the DOH.

Two caveats with this:

1. There could be a delay with September information reporting – so further hours may be added later;
2. The total hours and therefore costs include a mix of additional hours and costs [included in Covid-19 Monitoring returns as additional costs] and hours

and costs of staff resourced by the Trust already but working normal hours in Care home instead [not included as a cost in Covid-19 Monitoring returns].

This excludes other support to Care Homes in general from the Trust such as senior management, professional advice, designated leads, link workers and the Care Homes Response Team.

Cleaning

The Trust established a care homes response team and implemented the regional financial support grants for enhanced cleaning to support homes. This also included the provision of Trust staff to undertake cleaning in homes where this was required.

Technology

The Trust implemented the regional support grant for ipads and in tandem offered large tablet devices into homes to support communication between residents and families. The Trust piloted an automated system to record resident's vital signs in residential homes, however feedback from the homes was this was onerous and took staff away from direct care.

Staffing issues & levels

The Trust has supported workforce requirements within Care Homes since April 2020. A weekly workforce dashboard was collated over the course of the 1st wave of Covid 19 until 5/7/20 and during this time the Trust provided **483** shifts in the care home sector. This was further supplemented by all of the wrap around support outlined in the graphic at the start of this paper.

The Trust established the care homes response hub as a single point of access for homes experiencing staffing issues as a result of the pandemic. The care home response hub were managing a number of staff that were either redeployed, part of the workforce appeal or other willing to work shifts in care homes where there was a requirement. These staff were from community nursing, allied health professions and social care and recruited from the workforce appeal. The first requirement was for care homes to have considered their own contingency arrangements in respect of seeking agency cover or staff from other local providers. However often homes were often unable to source alternative staffing and given the immediate nature of the crisis the Trust attempted where possible to provide staff. The Trust found this challenging given the demands across all Trust services at the time. Providers gave the Trust feedback that the Trust was not always able to meet their staffing expectations.

Access to additional nursing staff was difficult but through the goodwill of community nursing staff the Trust was able to offer some support. These staff took on additional roles over and above their regular duties in an effort to support their colleagues.

There are significant concerns that it will be considerably more challenging to provide this level of support should it be required in a second surge. There are a number of reasons for this:

- Increased testing & contact tracing is resulting in significant numbers of staff not available to the workforce reducing the overall pool of staff available to draw from
- A number of staff who supported care homes in the first surge are now back working in their own service as it attempts to re-build
- Requirements to staff other initiatives such as the Whiteabbey Nightingale, potential accelerated opening of the Acute Services Block at the Ulster Hospital, the BCH Tower Block Nightingale – are all competing for staff
- Redeploying HSC contracted staff to support Independent Sector Homes remains a voluntary arrangement and staff can refuse

Close partnership working with Trusts, Providers, the Regulator, PHA, HSCB and DOH and Trade Unions **and** understanding of the challenges across the whole system will be continue to be crucial to managing expectations and delivering the best we can with the resources available to us.

Training & guidance

The Trust implemented specific induction programmes and guidance to support staff that had not previously worked in the care home sector to prepare them for the work they would be undertaking. The Trust sought to adopt a buddying system whereby staff were partnered to work shifts in pairs for support.

The Trust provided a wide range of training, guidance, advice and support to care homes based on regional guidance and the actions that the Trust was taking. The Trust also responded to provide guidance that was bespoke to each individual care home.

Experience gathered throughout the first phase was that practical experience in a nursing or residential care home setting is paramount for the individual, care home staff and resident when considering deploying staff into homes.

Staff pay and conditions

The Trust has been proactive in identifying staff who have and continue to support care homes where they have been unable to sustain services. Processes are in place to ensure, where possible, that staff are contacted in a timely fashion for their deployment to cover uncovered shifts. During the 1st wave this was facilitated in part through stepping down some Trust services, thus creating capacity for Trust staff to undertake these duties.

The Trust implemented the regional package of support for nursing homes to enable staff pay to be guaranteed.

Visitors

The management of visiting has been a particularly challenging issue for Care Homes. Balancing minimising the risk of infection transmission with the risk of the negative impact of resident's potentially not seeing family members for many months has been really difficult for providers and where particularly challenging cases have arisen the Trust has provided support through the resident's key worker and the Trust permanent placement team.

Homes have also been supported in a number of approaches, including the use of technology in relation to securing meaningful visiting arrangements based on the COVID risks at any point in time.

Homes have facilitated a range of visiting options and the Trust has supported them to facilitate visiting, particularly at end of life. The Trust also endeavoured to minimise the number of Trust staff entering care homes and adopted the host Trust arrangement to co-ordinate support.

Regulation: RQIA role, inspections & risk factors including public versus private ownership

As regionally agreed the Trust recognised RQIA as the communication conduit to Care Homes throughout the first surge. In relation to information that was provided and continues to be provided the Trust flagged issues with accuracy where providers had either omitted data or didn't update their returns. However this needs to be taken in the context that providers were under pressure and having to complete a range of information daily was onerous.

The Trust continues to engage with all partners in the delivery of care within care homes. Ongoing surveillance is supported by the care homes uploading data onto the RQIA website which in turn is shared and considered daily in the form of a Trust developed dashboard. This also supports link worker calls to care homes in completing checklists, dealing with queries and addressing any areas of concern.

Medical care within care homes and advanced care planning

Medical care within care homes is substantially provided through the GMS contract with GPs providing medical cover. The Trust has encouraged and supported person centred advanced care plans and anticipatory care plans being completed, documented and regularly reviewed.

During periods of outbreaks the Trust has taken the lead in providing enhanced clinical support through the Enhanced Care at Home Team. The Trust also established wrap around medical support through the Trust Clinical Director of Primary Care who also involved Secondary Care Consultant Geriatrician colleagues.

Where a resident becomes ill, access to acute medical advice is available to support residents to continue to be appropriately looked after in their care home. Where this is not possible step up of residents to COVID positive units, or where their clinical acuity requires it, to hospital, has been facilitated. The Trust established a bereavement support service for families and psychological support service through the Trust Clinical Psychology Service. In tandem the Trust developed and delivered a full training and education programme through the Trust Palliative Care Co-Ordinators to enhance care staff skills.

The Trust is now fully engaged in, and welcomes, the development of the Regional Enhancing Clinical Care in Care Homes Framework.

Preparedness within the HSC and in care homes: pre-COVID baselines and future requirements

The South Eastern Trust have a well-established Permanent Placement Team and Enhanced Care at Home Team which provide skills development and capacity/ resilience building and support for Nursing Homes, added to with virtual training via ECHO/ video conferencing organised specifically through the Trust in addition to other regional initiatives. The Trust also offered individual engagement sessions with all homes if required.

As a response to COVID pandemic, the Trust established daily contact with each Care Home. This contact, combined with data received daily from Care Homes via an app developed by RQIA, has given the Trust a daily surveillance insight into the health status of residents, staff availability and other key factors. Where possible the Trust deploys staff to assist in filling gaps in Care Home staff rotas at times of crisis although the challenges on delivering on this moving forward which have been outlined above cannot be over emphasized.

Co-ordination and Communication between DoH, Trusts and Care Homes

The Trust already has an established a Link Worker for each Care Home, to provide a direct line of communication and access to support. The Link Worker is a Trust professional who is aligned to the Trust Permanent Placement Team.

The aim of the Link Worker is to establish a relationship with the Care Homes they are assigned to and actively support the care homes to maintain safe service delivery and to assist to help resolve arising issues through access to a range of Trust Multi-Professional services and signposting to regional services such as

PHA/RQIA. The key responsibility of the Link Worker includes conducting in the first instance telephone support (daily at high of COVID surge and at a minimum of weekly) and surveillance calls using information already gathered from the RQIA App which has been completed by the care home staff.

The Trust established a single point of contact for provision of PPE to all Care Homes (and others) and a point to check to seek guidance on local operational arrangements, support with swabbing/testing, other general advice and guidance on responding to COVID pandemic.

Standards in place for infection control

The Trust dedicated two senior Infection Prevention and Control Nurses to provide support Care Homes in the South Eastern Trust area who were further supplemented by a team member from the PHA (PHA). Homes experiencing an outbreak of COVID 19 are prioritised for onsite visits and continued virtual support which is provided in collaboration with the PHA to assist with timely management of outbreaks.

However, in order to maintain good standards of infection control in Care Homes, the Infection Control Team has where possible, endeavoured to visit all Care Homes in the area and has provided verbal feedback on findings and a written report to support improvements where required, particularly focusing on control measures for COVID 19.

The Infection Control Nurse works closely with the Trust Link Workers and Home Managers to provide ongoing advice and support. Virtual training has been made available for Infection Prevention and Control including safe and effective use of PPE.

PPE stocks typically in place and usual levels of need

The Trust developed a PPE forecast to ensure that the appropriate stock levels of PPE were available for each home. This was ordered weekly by the home from the Trust central point.

Committee for Health

Mr S McGoran
Interim Chief Executive
South Eastern HSCT

By email: Valerie.Woods@setrust.hscni.net

Our Ref: C221/20

23 September 2020

Dear Mr McGoran

COVID-19 and Care Homes

The Committee for Health is conducting an inquiry into the impact of COVID-19 on Care Homes and is seeking the views of your organisation with a view to developing recommendations aimed at mitigating and managing a second surge in infections.

The Committee has gathered evidence from a wide range of stakeholders on this matter since March, which has informed the enclosed terms of reference and identified the following areas for particular consideration:

- Discharge from hospitals to care homes;
- Access to PPE;
- Testing in care homes;
- Funding and increased costs for care homes;
- Staffing issues & levels;
- Staff pay and conditions;
- Visitors;
- Regulation: RQIA role, inspections & risk factors including public versus private ownership;
- Medical care within care homes and advance care planning; and
- Preparedness within the HSC and in care homes.

The Committee feels it has a good sense of the problems experienced but is keen to develop constructive recommendations that will inform decision-making in coming months.

I would therefore be grateful if your evidence could focus on the steps required to minimise infections in care homes and care for those infected, while prioritising the care and wellbeing of all residents in the broadest sense as well as the wellbeing of staff. It would be very helpful if you could use the above headings to structure your response, subject to any additional suggestions you wish to make.

The above headings are supplemented overleaf by a list of sub-topics designed to illustrate, in a non-exhaustive way, the type of information that would be useful. Appendix 2 sets out the Committee's terms of reference.

I would grateful for your reply by 19 October in order to maximise the usefulness and timeliness of the Committee's report.

Yours sincerely,

Colm Gildernew MLA
Chairperson
Committee for Health

Enc.

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Appendix 1

Further information on topics of interest

- **Discharge from hospitals to care homes**
  - Testing prior to & post discharge
  - Isolation within care homes
  - Step-down facilities

- **Access to PPE**
  - Costs
  - Security of supply
  - Procurement: central v individual

- **Testing in care homes**
  - Effective frequency and management
  - Symptom monitoring
  - Personnel
  - Consent issues

- **Funding and increased costs for care homes**
  - Cleaning
  - Other infection control measures
  - Technology

- **Staffing issues & levels**
  - Additional staffing requirements;
  - Recruitment, regulation
  - Staff movement, shifts, roles
  - Training & guidance

- **Staff pay and conditions**
  - Sick pay
  - Environment including staff changing facilities
  - Other support

- **Visitors**
  - Virtual visiting
  - Socially distanced visiting
  - Wellbeing

- **Regulation**
  - RQIA role including inspections & advice
  - risk factors
  - HSC-run versus privately-run homes: impact/outcomes comparison

- **Medical care within care homes**
  - In-reach teams / support from Trusts & GPs
  - advance care planning

- **Preparedness within the HSC and in care homes: pre-COVID baselines and future requirements**
  - DoH consideration of care homes within pandemic plans
  - Coordination & communication between DoH, Trusts & care homes
  - Care homes:
    - standards in place for infection control
    - staff training including infection control, dealing with infectious disease outbreak
    - PPE stocks typically in place and usual levels of need /cost

Appendix 2

Aim of Inquiry

The aim of the Committee's inquiry is to produce recommendations to mitigate and manage the impact of a potential second surge of coronavirus on care homes.

Terms of Reference

The Committee will:

- Identify the key issues impacting care homes as a result of the COVID-19 pandemic;
- Identify domestic and international examples of best practice in arrangements to protect and care for residents of care homes during the pandemic; and
- Report to the Assembly on its findings and recommendations by **13 November 2020.**

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